

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-8  
09869

Reg. Dist. No. 62

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

Caroline

City or town.....

Dunkin Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

10 yrs.

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Elizabeth Dill

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Calvin

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age..... years

Jan. 9, 1863

8. AGE: Years

84

Months

11

Days

2

It less than one day

hrs.

min.

9. Birthplace.....

Whiteling, Del.

(Town, county, and state)

10. Usual occupation.....

Homemaker

11. Industry or business

MOTHER FATHER

12. Name.....

Thomas Green

13. Birthplace

Del - Unknown

14. Maiden name

Elizabeth Brown

15. Birthplace

Del - Unknown

16. Informant.....

Mrs Bessie Hopkins

Address

Easton, Maryland

17.

Burial, cremation, or removal (which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Easton, Md.

18. Funeral director.....

Earl W. Stafford

Address

Easton, Md.

19.

Date rec'd by registrar

19-47

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Caroline

City or town.....

Dunkin

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Mar 11 1947 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jesus 1947 to Mar. 11 1947  
and that I last saw her alive on Mar 9 1947

Immediate cause of death.....

Myocarditis

Due to.....

Arterio Sclerosis

DURATION

6 mos

5 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

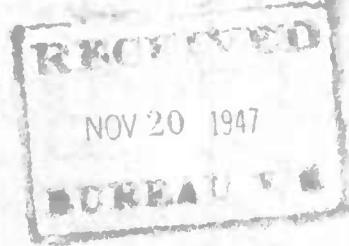
Injured at work?

23. SIGNATURE.....

James D. George  
Dunkin

M. D. or other

Address..... Date signed 11/12/47



PLEASE WRITE PLAINLY, WITH UNFADING INK  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

518

## CERTIFICATE OF DEATH

09870

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County Caroline  
 City or town Federalsburg - Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yearsHospital, Institution, or street address where death occurred: Federalsburg - Hullock RoadHow long in hospital or institution? 

## 3. (a) FULL NAME

Walter Van Grutynor

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
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6.(b) Name of husband or wife Annie Van Grutynor7. Birth date of deceased (mo., day, yr.) December 10, 1871

8. AGE: Years <u>75</u>	Months <u>10</u>	Days <u>28</u>	It less than one day hrs. <u></u>	min. <u></u>
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9. Birthplace France  
(Town, county, and state)10. Usual occupation Florist11. Industry or business Flowers and Shrubbery12. Name No data available

13. Birthplace

14. Maiden name No data available

15. Birthplace

16. Informant Mrs. Annie Van GrutynorAddress Federalsburg, Maryland, P.T.O.17. Burial Date thereof November 11, 1947  
(Burial, cremation, or removal, Which?) Burial (month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Federalsburg, Maryland18. Funeral director J. J. Trumpton and SonAddress Federalsburg, Maryland19. November 10 1947  
(Date rec'd by registrar) S.S. Freampton  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Federalsburg - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. Federalsburg - Hullock Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1947 at 9:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-7-47 to 11-8-47,  
and that I last saw h. 111 alive on 11-8-47.

Immediate cause of death Metastatic Carcroma  
to the Liver - with  
General debility

Due to Primary Carcroma  
17 yrs old.

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

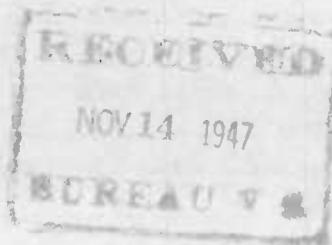
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

W. E. Lamm MD  
 M. D. or other \_\_\_\_\_  
 Address Federalsburg MD Date signed 11-10-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09871  
55e

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County CarolineCity or town Federalburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 yearsHospital, Institution, or street address where death occurred:  
Reliance Avenue

How long in hospital or institution?

## 3. (a) FULL NAME

Emma Hammond

## 4. Sex      5. Color or race      6.(a) Single, married, widowed, or divorced

Female      Colored      Married

6.(b) Name of husband or wife Charles W. Hammond7. Birth date of deceased (mo., day, yr.) May 25, 1896      6.(c) If alive, give age 52 years8. AGE:      Years      Months      Days      If less than one day  
51      5      29      hrs.      min.9. Birthplace Caroline County, Maryland  
(Town, county, and state)10. Usual occupation Housework11. Industry or business None12. Name Alexander Deakab13. Birthplace Caroline County, Maryland14. Maiden name Ella R. Satterfield15. Birthplace Caroline County, Maryland16. Informant Charles W. HammondAddress Federalburg, Maryland17. Burial Burial Date thereof November 26, 1947  
(Burial, cremation, or removal. Which?)      (month) (day) (year)Cemetery or crematory Saint Paul CemeteryLocation Near Concord, Maryland18. Funeral director J. J. Frampton & SonAddress Federalburg, Maryland19. November 25 1947  
(Date rec'd by registrar)      J. J. Frampton  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland      County CarolineCity or town Federalburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. Reliance Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1947 at 2:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 5th 1947 to Nov 23 1947and that I last saw her alive on Nov 23 1947

Immediate cause of death

Lung Osteoma at 89  
With general malnutrition

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Bilgey - Apr 5 1947

Mammary Hsg. Oct 11 1947 Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

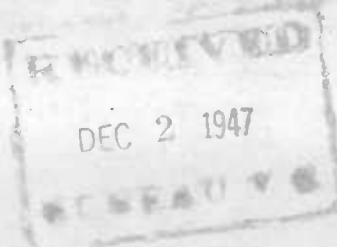
Accident, suicide, or homicide.      Date of

Where did injury occur?      (City or town)      (County)      (State)

Injured at home, farm, industry, public place (where?)

Means of Injury      Injured at work?

23. SIGNATURE W. E. L. Johnson MD  
M. D. or otherAddress Federalburg, Maryland Date signed 11/24/47



I

VS A15 9-45-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09872

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County CarolineCity or town Federalburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred:

216 Academy Avenue

How long in hospital or institution?

## 3. (a) FULL NAME

Maggie M. Harper

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

William James Harper

7. Birth date of deceased (mo., day, yr.)

November 23, 1868

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years  
79Months  
0Days  
5It less than one day  
hrs.      min.

9. Birthplace

Dorchester County, Maryland  
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

MOTHER FATHER

12. Name

No data available

13. Birthplace

Tucinda E. Griffith

14. Maiden name

Dorchester County, Maryland

15. Birthplace

Miss Naomi J. Harper

16. Informant

Federalburg, Maryland

17. Burial

Date thereof December 1, 1947  
(month) (day) (year)

Cemetery or crematory

Hill Crest Cemetery

Location

Federalburg, Maryland

18. Funeral director

J. J. Frampton & Son

Address

Federalburg, Maryland

19. December 1

19 47

J. S. Frampton

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Caroline

City or town

Federalburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

216 Academy Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 19 47 at 10:30 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 28 19 47 to Nov 28 19 47 and that I last saw her alive on Nov 28 19 47.

Immediate cause of death

Coronary Thrombosis 1 hr.

Due to

Due to

Other conditions

Chronic myocarditis 5 yrs.

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

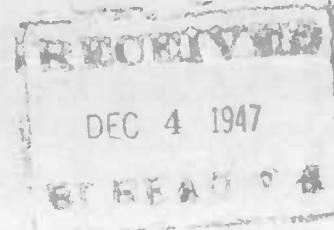
23. SIGNATURE

Frank M. Anderson M.D.

M. D. or other

Address

Federalburg, MarylandDate signed 12/1/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

09873

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County.....*Caroline*City or town.....*Denton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*life*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Lee Hignett*

4. Sex

M | W | Divorced

5. Color or race

6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) .....*UNKNOWN* 1873

6. (c) If alive, give age ..... years

8. AGE: Years ..... 74 Months ..... Days ..... If less than one day ..... hrs. ..... min.

9. Birthplace.....*Concord, Caroline, Md.*

(Town, county, and state)

10. Usual occupation.....*Farmer*11. Industry or business.....*Farming*12. Name .....*Elijah Hignett*13. Birthplace .....*Maryland*14. Maiden name .....*Ellen Murphy*15. Birthplace .....*Maryland*16. Informant .....*Mark Hignett*Address .....*Denton, Maryland*17. Burial .....*Burial* Date thereof ..... 11-22-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory .....*Concord*Location .....*Concord, Maryland*18. Funeral director .....*J. L. G. Hobson*Address .....*Denton, Maryland*

19. 11/21/47 Date rec'd by registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn, infants give residence of mother)

State.....*Ind*County.....*Caroline*City or town.....*Near Denton*

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... Nov 20 1947 at 8A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Nov. 20 1947

and that I last saw him alive on Nov 19 1947

Immediate cause of death

*Cerebral Hemorrhage  
Post-Dascular Head Disease*

DURATION

6 days - 3 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....*James D. George*

M. D. or other

Address.....*Denton MD* Date signed 11/21/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09874

1621

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

City or town.....

Paroline

Greensboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

5 months

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

m

5. Color or race

20

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Aug. 13<sup>th</sup> 1872

8. AGE:

Years  
75Months  
3Days  
5If less than one day  
hrs. min.

9. Birthplace.....

(Town, county, and state)

England

10. Usual occupation.....

House work

11. Industry or business

John Douglass

MOTHER FATHER

12. Name.....

Frederick

13. Birthplace.....

Ireland

14. Maiden name.....

Kate Keenan

15. Birthplace.....

Ireland

16. Informant.....

Welfare Board

Address.....

Caroline County

17. Burial.....

Date thereof.....

1/15/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Holly Cross Cemetery

Location.....

Near Denton

18. Funeral director.....

J. Virgil Moore

Address.....

Denton

19. (Date rec'd by registrar).....

11/14

Year.....

1947

Registrar.....

Mr. B. P. Jones

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Maryland Caroline

City or town.....

Denton

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Nov. 12 1947 at 8:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1944 to Nov. 12 1947

and that I last saw her alive on Nov. 10 1947

Immediate cause of death.....

Obstetric complications

DURATION

12 mos.

Due to.....

Astro-Sclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Denton Date signed 11/14/47

RECEIVED

NOV 17 1947

FEDERAL BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e  
09875

## CERTIFICATE OF DEATH

Dr. Reg. Dist. No. 84

## 1. PLACE OF DEATH:

County... *Caroline*City or town... *Glenmont*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

*The Stevens Nursing Home*

How long in hospital or institution?

*2 weeks*

## 3. (a) FULL NAME

*Mary E. Merkel*

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

*George Merkel*

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

*September 19, 1867*

8. AGE:

Years

Months

Days

If less than one day

80

2

1

hrs. .... min.

9. Birthplace

*Library Pennsylvania*

(Town, county, and state)

10. Usual occupation

*Housework*

11. Industry or business

*None*

12. Name

*No data available*

13. Birthplace

*No data available*

14. Maiden name

*No data available*

15. Birthplace

*No data available*

16. Informant

*Mrs. Edward F. Boles*

Address

*Federalburg, Maryland, R.F.D.*

17. Burial

*Burial*

(Burial, cremation, or removal. Which?)

*Date thereof November 22, 1947*

(month) (day) (year)

Cemetery or crematory

*Hill Crest Cemetery*

Location

*Federalburg, Maryland*

18. Funeral director

*J. J. Frampum & Son*

Address

*Federalburg, Maryland*

19. November 22 1947

*(Date rec'd by registrar)**J. J. Frampum*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland*County... *Oxford*City or town... *Federalburg**Park*

(If outside city or town limits, write RURAL and give nearest town)

Street No... *Hospital Road*

(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (b) Social Security Number

*None*

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

*November 20 1947 at 6:54 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *September 8 1947* to *Nov 20 1947* and that I last saw her alive on *November 19 1947*.

Immediate cause of death

*Arteriosclerosis of Otolow.**Obstructive Obstruction*

Due to

Due to

Other conditions

*Chronic Myocarditis*

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

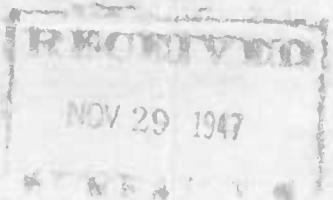
23. SIGNATURE

*Charles H. Stoenesbaker*

M.D. or other

Address

*Greensboro Md.*Date signed *11-20-47*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09876

Reg. Dist. No. 61

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County CarolineCity or town Greensboro Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? non

## 3. (a) FULL NAME

Alfred Mosley

4. Sex

Male

5. Color of face

Color

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Single

7. Birth date of deceased (mo., day, yr.)

Sept 5

8. (c) If alive, give age years

1909

8. AGE:

38

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Delaware

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

Tenoch Mosley

12. Name

Tenoch Mosley

13. Birthplace

Delaware

14. Maiden name

Mary E Mosley

15. Birthplace

Delaware

16. Informant

Mary E Mosley

Address

Greensboro. M.D.

17. Burial

Buried Date thereof Nov 19 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Fair Branch Cemet

Location

New Dorav. Del

18. Funeral director

Calvin Blaspi

Address

102 10 Main St Donegal

19. Date rec'd by registrar

Nov 18 1947 L. M. Pippin

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Md.

County

Caroline CountyCity or town Greensboro

County

Greensboro

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

no

## MEDICAL CERTIFICATION

20. DATE OF DEATH

November 16 1947 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1947 to Nov. 16 1947and that I last saw him alive on November 15 1947

Immediate cause of death

Cirrhosis of liver

Due to

Due to

Pneumonia

Other condition (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

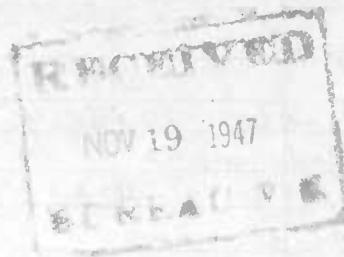
Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Clark H. Houshfield M. D. or D.V.M.Address Greensboro Md. Date signed Nov 16 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Write the causes of death clearly and legibly. Is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09877

Reg. Dist. No. 64

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County *Caroline*City or town *Federalsburg*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *life*Hospital, institution, or street address where death occurred: *North Main Street*

How long in hospital or institution?

## 3. (a) FULL NAME

*Edith J. Mowbray*

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

*William A. Mowbray*

7. Birth date of deceased (mo., day, yr.)

February 28, 1866

6.(c) If alive, give age years

8. AGE:

Year

Months

Days

If less than one day

81

8

22

hrs.

min.

9. Birthplace

*Federalsburg, Maryland*

(Town, county, and state)

10. Usual occupation

*Housework*

11. Industry or business

*Home*

12. Name

*Charles W. Jefferson*

13. Birthplace

*Dorchester County, Maryland*

14. Maiden name

*Caroline J. Lamp*

15. Birthplace

*Probably Talbot County, Maryland*

16. Informant

*Miss Delia M. Mowbray*

Address

*Federalsburg, Maryland*

17. Burial

Date thereof *November 22, 1947*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

*Hick Crest Cemetery*

Location

*Federalsburg, Maryland*

18. Funeral director

*J. J. Freampton & Son*

Address

*Federalsburg, Maryland*

19. November 22 1947

(Date rec'd by registrar)

*S. J. Freampton*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Caroline*City or town *Federalsburg*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *North Main Street*

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

*None*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *November 20 1947* at *12:30 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb. 3rd* 1947 to *Nov 20th* 1947 and that I last saw her *alive* on *Nov 20th* 1947

Immediate cause of death

*Chronic Myo Myo Cardiopathy  
with myo pericarditis*

DURATION

*10 yrs*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

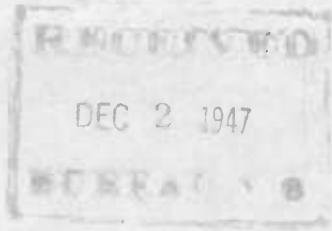
Injured at work?

23. SIGNATURE

*W. E. Jefferson MD*

M. D. or other

Address *Federalsburg, Maryland* Date signed *11-22-47*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

## CERTIFICATE OF DEATH

098782

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

*Caroline*

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

*Sole*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*M**w*

married

6.(b) Name of husband or wife

*Lillie Nichols*

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo. day. yr.)

*Nov. 17, 1876*

8. AGE:

Years  
70Months  
11Days  
14If less than one day  
hrs. min.

9. Birthplace

*Harmony, Caroline, Md*

(Town, county, and state)

10. Usual occupation

*Clothing Store*

11. Industry or business

*Jas H Nichols*

MOTHER FATHER

12. Name ..... *Jas H Nichols*13. Birthplace ..... *Dorchester Co. Md*

MOTHER

14. Maiden name ..... *Lillie Parsons*

FATHER

15. Birthplace ..... *Caroline Co. Md*16. Informant ..... *Lillie Nichols*

Address

*Denton, Maryland*

17. Cemetery or crematory

*Burial*Date thereof ..... *Nov. 3, 1947*  
(month) (day) (year)

Location

*Denton Cemetery*

18. Funeral director

*J. Virgil Morris Son*

Address

*Denton, Md.*

19.

11/3 1947  
(Date rec'd by registrar)19. *MD George*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

*Md*

County.....

*Caroline*

City or town.....

*Denton*

Street No.....

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Nov. 1 1947* at *1A*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Nov. 22 1943* to *Nov. 1 1947*and that I last saw him alive on *Oct. 31 1947*

Immediate cause of death

*Hypertensive heart disease*

DURATION

*4 yr*

Due to

Due to

Other conditions *Coronary arter. disease* 3 yr

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

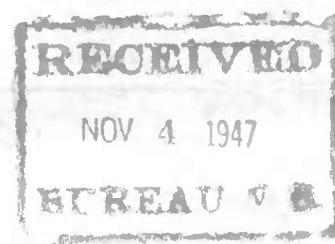
23. SIGNATURE

*Paul Throth M.D.*

M. D. or other

Address

*Denton Md*Date signed *11/3/47*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09879

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County.....

Caroline

City or town.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

66 yrs.

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Lizzie George Redden.

4. Sex

F

5. Color or race

bl.

6.(a) Single, married, widowed, or divorced

widow

## 6.(b) Name of husband or wife

Frank Redden (deceased)

## 7. Birth date of deceased (mo., day, yr.)

Aug. 12<sup>th</sup> 1860

5.(c) If alive, give age..... years

## 8. AGE:

Years

87

Months

3

Days

0

If less than one day

hrs.

min.

## 9. Birthplace

Tuscarora Del.

(Town, county, and state)

## 10. Usual occupation

at home

## 11. Industry or business

MOTHER FATHER

George Phillips

## 12. Name

Delaware

## 13. Birthplace

Caroline Cannon

## 14. Maiden name

Blanche Hobbs

## 15. Birthplace

Blanche Hobbs

## 16. Informant

Blanche Hobbs

## Address

Weston Ind.

## 17. Burial

Buried

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

## Cemetery or crematory

Weston Cemetery

## Location

Weston Maryland

## 18. Funeral director

J. Virgil Moore &amp; Son

## Address

Baltimore Md.

## 19. 11/13/47

Date rec'd by registrar

1947

11/13/47

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Caroline

City or town.....

Wauhatchie

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Nov. 12 1947 at 8:29 AM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1943 to Nov. 12 1947

and that I last saw her alive on Nov. 12 1947

## Immediate cause of death

Chronic Hypertension. 10 yrs.

## Due to

## Due to

Chronic Arthritis. 12 yrs.

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

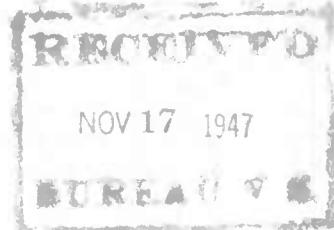
Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

Hansel D. George M. D. or other

Dr. D. George Address Date signed 11/13/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09880  
938

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County.....*Caroline*City or town.....*Denton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*30*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Emma Lucas Rutter*

## 4. Sex

*F*

## 5. Color or race

*W*

## 6.(a) Single, married, widowed, or divorced

*widowed*

## 6.(b) Name of husband or wife

*Walter Rutter*

## 7. Birth date of deceased (mo., day, yr.)

*June 14, 1871*

.....(c) If alive, give age.....years

## 8. AGE:

Years  
*76*Months  
*4*Days  
*16*If less than one day  
hrs. .... min.

## 9. Birthplace.....

*Bethesda, Maryland, Md.*

(Town, county, and state)

## 10. Usual occupation.....

*Housewife*

## 11. Industry or business

## MOTHER FATHER

12. Name.....*Wm. D. Jones*13. Birthplace.....*Caroline Co*14. Maiden name.....*Luisa Jones*15. Birthplace.....*Chesterville, Md*

## 16. Informant.....

*Wm. John Bagg*

## Address

*Denton, Md.*

## 17. Burial

Date thereof.....*Nov 3, 1947*  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)

## Cemetery or crematory

*Denton*

## Location

*Denton, Md.*

## 18. Funeral director.....

*J. Virgil Mooreton*

## Address

*Denton, Md.*

## 19. Date rec'd by registrar

*11/3 1947*

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md.*County.....*Caroline*City or town.....*Denton*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH.....

*Nov. 1*

19

*47* at *12:30 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec.*

19

*47*, to *Nov. 1*19*47*and that I last saw her *alive* on *Nov. 1*19*47*

## Immediate cause of death.....

*Chronic Myocarditis*

DURATION

*3 yr*

Due to.....

*Arteriosclerosis**5 yr*

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op.

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

## Means of injury.....

Injured at work?

## 23. SIGNATURE.....

*Alanson D George*

M. D. or other

Address.....*Denton*Date signed *11/3/47*

RECEIVED

NOV 4 1947

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09881  
93d

Reg. Dist. No. 61

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

*Caroline*

City or town.....

*Near Denton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

*24 years*

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

*F*

5. Color or race

*W*

6. (a) Single, married, widowed, or divorced

*married*

6. (b) Name of husband or wife

*Geo Shaffer*

7. Birth date of deceased (mo. day, yr.)

*- 1885*

6. (c) If alive, give age ..... years

*67*

8. AGE:

*62*

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

*Virginia*  
(Town, county & state)

10. Usual occupation.....

*at home*

11. Industry or business

*Linen Supplies*

MOTHER FATHER

12. Name .....

*Linden Shaffer*

13. Birthplace

14. Maiden name

*Mary Sidney R. Rockhart*

15. Birthplace

*Gore, Va.*

16. Informant

*Geo Shaffer Husband*

Address

*Bl. Denton Md.*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

*Denton Cemetery*

Location

*Denton Md.*

18. Funeral director

*J. Virgil Moore & Son*

Address

*Denton Md.*

19. Date rec'd by registrar

*Nov. 13, 1947 L. M. P. J. V. M.*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

*Md*

County.....

*Caroline*

City or town.....

*Near Denton*

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*November 10 1947*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Aug. 4 1947 to Nov. 10 1947*and that I last saw him/her alive on *Nov. 10 1947*

Immediate cause of death

*Pleural Pulmonary Edema*

DURATION

Due to

*Hypertensive Disease*

Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury

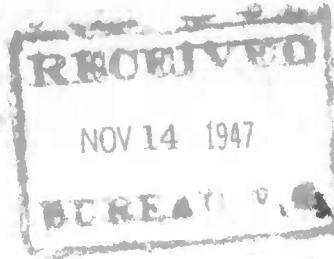
Injured at work?

23. SIGNATURE

M. D. for

Address..... Date signed.....

*George W. Pease Nov. 13, 1947*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9/4/47

09882

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County CarolineCity or town Preston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

CHARLES WILLIAM TALLMAN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MWMarried

6. (b) Name of husband or wife

Alice M. Tallman6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.)

October 17, 1899

8. AGE:

Years 48Months 19

Days

If less than one day

hrs. .... min.

9. Birthplace

Cresskill, N. J.

(Town, county, and state)

10. Usual occupation

Banker

11. Industry or business

MOTHER FATHER

12. Name Egbert Tallman13. Birthplace Cresskill, N. J.14. Maiden name Emma L. Voorhis15. Birthplace Demarest, N. J.16. Informant Mrs. Alice M. TallmanAddress Preston, Md.

17. Burial

Date thereof Nov. 10, 1947  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)Cemetery or crematory Brookside, N. J.Location Englewood, N. J.18. Funeral director W. H. Hollis & SonAddress Preston, Md.19. Nov. 6 1947  
(Date rec'd by registrar)C. D. Plummer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarolineCity or town Preston

(rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

146-05-2267

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 5th 1947 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 5 1947 to November 5 1947and that I last saw h. in alive on November 5th 1947

Immediate cause of death Acute Coronary Occlusion

DURATION

1 Hr

Due to Coronary Sclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H. C. Stearns, M.D.

M. D. of other

Preston Maryland

Date signed

11/6/47

RECEIVED

NOV 8 1947

REAU-CB

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09883

Reg. Dist. No. 61

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: Caroline  
 County Greensboro Rural  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 47 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 Street No.   
 (If rural, give LOCATION)

3. (a) FULL NAME Robert Zacharias  
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 24 - 1873  
 8. AGE: Years 74 Months 8 Days 0 If less than one day  hrs.  min.

9. Birthplace Greensboro Caroline Md.  
 (town, county, and state)

10. Usual occupation Farmer

11. Industry or business Daniel J. Zacharias

12. Name Daniel J. Zacharias

13. Birthplace Penna.

14. Maiden name Susan Moyer

15. Birthplace Penna.

16. Informant Miss. Maria Zacharias

Address Greensboro Md.

17. Burial Greensboro

(Burial, cremation, or removal, which?)

Date thereof 11/26/47  
 (month) (day) (year)

Cemetery or cemetery plot Greensboro

Location Greensboro Md.

18. Funeral director R. B. Rawlings

Address Greensboro Md.

19. Date rec'd by registrar Nov. 25, 1947

(Date rec'd by registrar)

Registrar L. M. Lippin

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION			
20. DATE OF DEATH	<u>Nov. 24</u> 1947 at 12:45 A.M.		
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Nov. 21</u> 1947 to <u>Nov. 24</u> 1947 and that I last saw him alive on <u>Nov. 23</u> 1947.			
Immediate cause of death <u>Coronary Occlu. or Extent &amp; electric cardiac vascular disease</u>			
Due to			
Due to			
Other conditions			
(Include pregnancy within 3 months of death)			
Major findings of operations			
Autopsy results			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident, suicide, or homicide..... Date of.....			
Where did injury occur? (City or town) (County) (State)			
Injured at home, farm, industry, public place (where?)			
Means of injury			
Injured at work?			
23. SIGNATURE <u>Charles W. Stonerfield Jr.</u> M. D. or other <u>Surgeon</u> Date signed <u>24 Nov 1947</u>			
Address			

RECEIVED

NOV 29 1947